COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: December 4, 2014

TO: Kimberly Walker, Chairwoman, and Pete Carlson, Vice Chairman
Milwaukee County Mental Health Board

FROM: Susan Gadacz, Director, BHD/Community Access to Recovery Services
Co-Chair, Mental Health Redesign and Implementation Task Force

SUBJECT: From the Mental Health Redesign and Implementation Task Force, submitting an informational report on system redesign efforts and the 2013-2014 SMART Goals

Background

The Mental Health Redesign and Implementation Task Force was chartered in 2011 with the purpose of developing and implementing a data-driven plan for the effective and sustainable redesign of the mental health system in Milwaukee County (see Attachment 1, *Mental Health Redesign and Implementation Task Force Charter*).

The Task Force established Action Teams to address key areas of the redesign effort: Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. (A Cultural Intelligence Action Team was added in 2013.) The initial deliberations of the Action Teams were based on various proposals recognized by the County Board of Supervisors in its charge to the Task Force:

- *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative (see Attachment 2, *Progress on HSRI 2011 Report Recommendations*)
- Reports to the Board of Supervisors from the Community Advisory Board for Mental Health
- *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division* by the Milwaukee County Department of Audit
- *Follow-Up Report to BHD Administrator: Mixed-Gender Units* by the Gender Unit Work Group
- *Milwaukee County Executive's Mental Health Vision and Initiative* by Chairman Lee Holloway
- Reports to the Board of Supervisors from the New Behavioral Health Facility Study Committee

The studies yielded over 120 recommendations, which were categorized and assigned to Action Teams for review, adaptation, and prioritization starting in October 2011 (see Attachment 3, *Task Force and Action Team Organizational Chart*). The Action Team co-chairs presented their prioritized recommendations to the Health and Human Needs Committee in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. The Task Force and DHHS and BHD leadership resolved in March 2012 to issue a Request for Proposals for technical assistance in implementing the recommendations. DHHS contracted with a consultation team led by ZiaPartners, Inc., from September 2012 through July 2013. To promote clear reporting, implementation activities were framed as SMART Goals (see Attachment 4) – Specific, Measurable, Attainable, Realistic, and Time-bound. The County Board of Supervisors passed a resolution in March 2013 authorizing the DHHS Director to implement the initiatives outlined in the SMART Goals in collaboration with the Task Force and community stakeholders. The Task Force, Action Teams, and numerous public- and private-sector partners worked throughout 2013 and 2014 to complete the SMART Goals, and a Mental Health Redesign Working Forum brought together nearly 100 partners to

assess progress, address remaining tasks toward SMART Goal completion, and strategize for future collaboration for system improvement (summary report at county.milwaukee.gov/MHRedesign.htm). The Task Force and Action Teams – as well as affiliated workgroups – have continued to meet since the Forum to assess and support SMART Goal progress.

Discussion

Each of the SMART Goals was developed around a particular aim, with performance targets and tactical objectives to support that aim. The overarching aims of these SMART Goals have been achieved. Selected progress points for each SMART Goal are presented below. A more complete table of related activities is attached (see Attachment 5, *SMART Goal Achievements and Opportunities*).

Goal 1. Improve satisfaction and recovery outcomes
- Revised MHSIP satisfaction survey to be more welcoming, person-centered
- Improvement in all MHSIP domains on BHD adult inpatient units; high marks (above 75%) in community services
- Implemented Integrated Dual Disorder Treatment at CARS and community providers

Goal 2. Reduce stigma around mental illness
- Developed stigma reduction curriculum for community events, including personal stories from persons with lived experience of mental illness
- Presented stigma reduction program at multiple public events; Action Team working with Pastors United and UCC to organize presentations in churches and in Spanish
- NAMI presented an anti-stigma, recovery-themed theatrical production (*Pieces: In My Own Voice*) in various venues

Goal 3. Workforce development and improvement
- Over 500 individuals from dozens of community agencies involved in MC3 activities
- Employee trainings on trauma-informed care, co-occurring competencies, etc.
- Faye McBeath Foundation led a collaborative partnership called Nursing's Voice to address the supply and capacity of mental health nurses in the Milwaukee area

Goal 4. Expand network of Certified Peer Specialists
- Increased Certified Peer Specialists in Milwaukee County sevenfold since 2011
- Established Peer Pipeline website (hosted by Mental Health America)
- Conducted trainings for employers on integration of peer support into service array
- Conducted training for Spanish-speaking peers

Goal 5. Improve coordination and flexibility of mental health funding
- Implemented Community Recovery Services (CRS) and Comprehensive Community Services (CCS) to expand array of Medicaid-reimbursable services

Goal 6. Publicly chart system quality indicators
- Published data dashboard on County website in January 2014, updated quarterly

Goal 7. Structure for ongoing system improvement and oversight
- Maintained productive partnership of public and private stakeholders since July 2011
- MC3 Change Agent network plans and conducts quality improvement projects

Goal 8. Improve crisis response, reduce emergency detentions
- EDs reduced overall and as a percentage of total PCS admissions
- Expanded hours for mobile crisis services
- Increase in person-centered crisis plans on file for BHD clients

Goal 9. Flexible availability and continuity of community-based recovery supports
- Expanded Targeted Case Management slots, including new Recovery level

- Implemented CRS and CCS, new Medicaid psychosocial rehabilitation benefits
- Added new Access Clinic location on south side of Milwaukee
- All Central Intake Units became Certified Application Counselors to assist clients with insurance enrollment through the Health Insurance Marketplace

Goal 10. Improve transitions after hospital admission

- Established Community Linkages and Stabilization Program (CLASP)
- Housing Division created Community Intervention Specialist position to facilitate discharge planning, housing placements

Goal 11. Improve economic security of persons with mental illness

- Winged Victory provided benefits application assistance to more individuals, increased percentage of approvals

Goal 12. Increase consumer engagement in employment, education

- Implemented Individual Placement and Support (IPS) employment model
- Improved employment status of CARS consumers from intake to six-month follow-up

Goal 13. Recovery-oriented supportive housing

- Opened Pathways to Permanent Housing program
- Supported Clarke Square neighborhood initiative for transitional youth
- Increased number of supportive housing units

Goal 14. Collaboration between mental health and criminal justice systems

- Participated in Community Justice Council analysis of high utilizers of both systems
- Targeted interventions to stabilize repeat users of resource-intensive services

Goal 15. Improve access to non-hospital interventions, reduce hospitalizations

- Reduced BHD Adult Inpatient admissions from 1,650 in 2012 to 1,163 in 2014 (projected), completing a 48.4% decrease since 2010
- Serving 14% more individuals (4,572) in community-based services than in 2010
- Expanded array of community services (e.g. CCS, CRS) to respond to diverse needs

Goal 16. Improve cultural intelligence

- Developed cultural intelligence training curriculum and began trainings of Action Team leaders, CARS staff, and other partners

The SMART Goals were developed as a time-bound road map for specific initiatives in 2013 and 2014, but they are not an exhaustive inventory of all activities contributing to the improvement and redesign of the local mental health system. The Task Force has operated as a community-wide collaboration in pursuit of goals and objectives that are complementary to – but largely distinct from – other major County-specific initiatives. These initiatives include, but are not limited to, implementation of Electronic Medical Records, the use of evidence-based programming within CARS, and transitioning long-term care consumers from BHD into person-centered, community-based settings.

While the redesign initiatives that were facilitated, aided, or observed by the Task Force shouldn't be construed as conclusive, it is important to recognize that the mental health system in Milwaukee County has seen significant, positive change since 2011. There is a steady, thoughtful, enthusiastic, and ongoing shift toward more recovery-oriented, person-centered care. With the completion of the SMART Goals, the Task Force now looks to the Mental Health Board to build upon these changes as it fulfills its charge.

Recommendations

The Mental Health Board should support the work of a **Prevention and Early Intervention Action Team**, which emerged as an area of interest at the Working Forum. The CARS Prevention Coordinator presented to the Task Force and has begun recruitment and planning for this group to move forward.

Task Force stakeholders are also eager to work with the Board (consistent with its charge) to expand and make effective use of **diversion programs**, including the Adult Drug Treatment Court, Family Drug Treatment Court, and Mental Health Court.

Improving cultural intelligence remains a priority for all stakeholders beyond the time-bound scope of SMART Goal 16. The Board should support the continuing work of the **Cultural Intelligence Action Team** (CQAT) and receive periodic reports from the CQAT chairs. The goal of the CQAT is "to conceptualize the framework to expand and ensure that cultural intelligence endures throughout and beyond the Redesign efforts. This framework should instruct, equip, and offer care providers the tools to effectively interact with care recipients in culturally intelligent and appropriate manners as deemed by the care recipients." A comprehensive report from the CQAT is included with this report (see Attachment 6).

The Quality Action Team (QAT) has focused on establishing a mechanism to publicly chart system quality indicators. Its monthly meetings engaged roughly 30 participants from more than a dozen different public and private organizations, and work was delegated to three subgroups: System Mapping, Personal/Family Stories, and Dashboard. In partnership with Rogers InHealth and the Wisconsin Initiative for Stigma Elimination, the **Personal/Family Stories** group established a mechanism for collecting video vignettes of personal stories to be used for quality improvement, and the first story was recorded in July 2014. This work should be continued and supported. Another QAT product to be maintained is the **online data dashboard** published in January 2014 and updated quarterly (pursuant to SMART Goal 6). The Board should consider how to refresh this tool periodically and add or remove indicators to ensure continuing relevance and transparency. The QAT recommends that the Board **pursue data-sharing agreements with private hospitals** to consolidate County-wide data for presentation on the dashboard, initially focusing on inpatient admissions. Tracking inpatient admission data across public and private systems will help administrators and policy makers assess the impact of redesign initiatives, as well as to identify and monitor areas of continuing or emergent needs. Successful and beneficial data-sharing agreements and dashboarding may warrant addition of more data points.

The Board should support and communicate regularly with the **Milwaukee Co-Occurring Competency Cadre (MC3)** and its subcommittees, including the **Person-Centered Care Action Team**. The MC3 unites Change Agents from all types of community providers, promoting self-assessments, trainings, and quality improvement projects. Related to SMART Goal 1, the Person-Centered Care Action Team recommends that BHD work with an academic partner to process satisfaction data.

The Continuum of Care Action Team pursued the idea of a **SOAR Collaborative** to assist eligible clients with benefit applications, but the execution of the plan ran short of time and personnel. This should be considered again with the support of the Board.

Lastly, the Task Force recognizes that further efforts are needed to **promote employment and education** as components of mental health recovery. The Board should consider how it might take action or support other efforts to that effect.

The successes of the Redesign Task Force and Action Teams attest to the collective capability and passion of the more than one hundred contributors from dozens of public and private entities who stepped up to channel their efforts into this fruitful collaboration. The Task Force has been a central force in the ongoing adaptation of our mental health system to better promote recovery, and the Mental Health Board should strongly consider how it might build upon the achievement of the SMART Goals and utilize the structures and relationships that this work has cultivated.

Mental Health Redesign and Implementation Task Force Charter

Purpose: To develop and implement a data-driven plan for the effective and sustainable redesign of the mental health system in Milwaukee County

Background and Rationale:
Mental health service delivery in Milwaukee County has been the subject of considerable research and scrutiny in recent years. Numerous public and private entities have issued reports on how to modernize and improve the mental health system generally as well as the Behavioral Health Division specifically, including (but not limited to):

- *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative, Inc.
- Reports to the Milwaukee County Board of Supervisors from the Community Advisory Board for Mental Health
- *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division* by the Milwaukee County Department of Audit
- *Follow-Up Report to BHD Administrator: Mixed-Gender Units* by the Gender Unit Work Group
- *Milwaukee County Executive's Mental Health Vision and Initiative* by Chairman Lee Holloway, Milwaukee County Board of Supervisors
- Reports to the Milwaukee County Board of Supervisors from the New Behavioral Health Facility Study Committee

The Board of Supervisors approved a resolution in April 2011 to create a task force charged with evaluating and selectively implementing recommendations contained in the various reports.

Guiding Principles:

- Adherence to SAMHSA recovery principles: Self-Direction, Individualized and Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope
- Ensuring access to high quality services and supports in community-based settings
- Reducing reliance on emergency services and unnecessary inpatient care
- Commitment to full inclusion of consumers as well as family members and advocates
- Partnership between public and private stakeholders
- Compliance with the integration mandate of the ADA and *Olmstead v. L.C.*
- Diversity and cultural competency
- Moving beyond the medical model to a philosophy of independent living

Scope and Boundaries:

- Included:
    - Geography: Milwaukee County (and inpatient programs within the five-county region)
    - Focus: Redesign of Milwaukee County Behavioral Health Division services in coordination with reconfiguration and expansion of private and State-sponsored programs and services
    - Age Demographic: Initial focus on adults (including geriatric patients) and transitional youth
    - Range of Services: Inpatient, outpatient, emergency/crisis, case management, peer support, long-term care, residential, prevention, substance abuse services, and community-based services including (but not limited to) CSP, TCM, Day Treatment, and Family Care
    - Clinical Populations: Persons with mental illness and substance abuse, including those with a dual diagnosis and/or developmental disabilities
    - Focus on vulnerable, low-income populations, including the uninsured, Medicaid beneficiaries (and dual eligibles), older adults, and persons under emergency detention

  - System and structural redesign of the delivery system
  - Legal and public policy changes associated with emergency detention services
  - *Interaction* with external systems, e.g., housing, employment, education, justice, etc.
- Excluded:
  - Areas outside of Milwaukee County (excepting certain other inpatient programs within the five-county region)
  - Day-to-day operations and improvements at the Behavioral Health Division
  - Children's mental health
  - *Redesign* of external systems
    - e.g., housing, employment, education, criminal justice, etc.

Objectives/Deliverables:

- Review, prioritize, and implement recommendations from evidence-based plans and proposals
- Improve access to timely and appropriate mental health services
- Expand public and private community-based mental health services
- Reduce unnecessary and costly reliance on inpatient treatment
- Determine and achieve optimal capacities in public and private inpatient facilities and the Hilltop units at the BHD
- Minimize use of emergency detentions
- Improve consumer satisfaction and quality of care
- Achieve system-wide application of principles of recovery and trauma-informed care
- Increase independence, community integration, and quality of life for consumers
- Manage or reduce overall costs within the mental health system
- Garner and maintain support from the governing boards of mental health stakeholder entities, notably those represented on the Task Force
- Achieve and maintain an efficient, well trained workforce through strong recruitment, retention, and continuing education efforts

Outcome Measures:

- Expansion of community-based services
- Shift of inpatient capacity from public to private facilities
- Decreased emergency detentions
- Decreased readmissions
- Establishment of a set of common quality metrics
- Increased application of the recovery model and trauma-informed care
- Increased consumer satisfaction

Related Initiatives/Teams:

- Behavioral Health Advisory Committee
- Mental Health Task Force
- Milwaukee Continuum of Care
- Community Advocates – AODA Initiative

Resources Required:

- Project management support
- Technical assistance (fiscal analysis, policy implementation expertise)

Timeframe:

- Quarterly reports to the Committee on Health and Human Needs
- Major report on implementation plans to County Board in January 2012

Attachment 2 – Progress on HSRI 2011 Report Recommendations

HSRI Rec 1: Downsize & redistribute inpatient capacity

- BHD has continually reduced the number of inpatient units and the total occupancy.
    - *Closed a unit (43D) in 2012, a 24 inpatient bed reduction.*
    - *On the Acute Inpatient Units, in 2011 BHD staffed 108 beds. In 2013 those beds the number of staffed beds was down to 78. That is a 39% reduction in the total number of beds.*
    - *There has been a 48% reduction in the average daily census from 2008 – 2014.*
    - *Care has been redistributed to private institutions and community providers.*
    - *Projected admissions to acute inpatient in 2014 is 1,163; this is down from 2,254 in 2010.*
- DHHS/BHD has also worked with the State to develop and implement plans to phase down the long term care units (Hilltop & Central).
    - *In February 2013 the County Executive announced plans to close the long-term care units. This summer the State approved closure plans for both Hilltop and Central Services to be delivered in smaller community homes with support*
    - *On the long term care units, 18 individuals have been relocated to the community from Hilltop through the downsizing relocation plan from 2012.*
    - *In September 2010 the census at Hilltop was 68; in November 2013 the census is 50, in September 2014 the census is 34.*
    - *In September 2010, the licensed bed capacity at Central was 70, the census as of November 2013 is 50, and the census in September 2014 is 34.*

HSRI Rec 2: Involve private systems in a more active role

- BHD has been working with private providers to build clinical capacity to treat persons with more severe psychiatric symptoms and needs.
    - *In 2012 Aurora opened a 24 bed unit specifically dedicated to take higher acuity patients from BHD.*
    - *BHD is in discussions with private health system providers in the community to establish contracts to taking on indigent persons in need of mental health services.*
    - Rogers has plans to add 26 adult psychiatric beds in their brown deer facility in 2015.
    - The Hospital systems now operate 68% of the psychiatric beds in this community while also accounting for 85% of total psychiatric admissions. That will likely go up in 2015.
    - *28% of individuals were transferred from our Psychiatric Crisis Service to private treatment facilities.*

HSRI Rec 3: Reorganize crisis services & expand alternatives

- Since 2012, BHD has two Crisis Resource Centers located in the northern and southern parts of the county in order provide easier access for consumers.
- In 2012, two additional crisis stabilization/respite homes were opened. One respite location for individuals with intellectual disabilities and one stabilization home for individuals who live with mental illness.
- As of September 2014 there are 53 crisis stabilization beds.
- The Community Linkages and Stabilization Program (CLASP) launched in 2012. CLASP is a program that focuses on a successful discharge planning and community reintegration that is delivered in a peer-to-peer approach.
- Mobile Crisis Team expanded to provide a maximum amount of availability with 24/7 coverage.
- In 2013, Milwaukee Police Department also added a member to the Mobile Crisis Team and will enhance their partnership with BHD by adding another member in the upcoming year.
- In September 2014, a contract with La Causa was established to create a 3rd shift Crisis Mobile Services.

Attachment 2 – Progress on HSRI 2011 Report Recommendations

HSRI Rec 4: Reduce emergency detentions

- There has been a 29.6% decrease in Emergency Detentions from 2010- 2014
- In 2014, a change to state statutes that broadened the definition of who is authorized under Chapter 51 to make Emergency Detention determinations will likely result in diverting emergency detentions for other alternatives
- The Housing Division is working more closely with private hospitals and the House of Corrections to enhance successful discharge planning via a newly hired Community Intervention Specialist position, which was developed out of the Community Linkages Action Team.

HSRI Rec 5: Expand & reorganize community-based services

- Received authorization in August 2013 to implement the Community Recovery Services (CRS) benefit via the 1915i Medicaid Waiver as of September 2014, 66 clients are enrolled in CRS.
- BHD made a significant investment in shifting resources to community-based services and expanding community-based capacity.
    - CEX $3 million in 2012 & 2013, some of the funded initiatives included:
        - *CLASP*
        - *Northside CRC*
        - *Crisis Respite for individuals with an intellectual disability*
        - *Crisis Stabilization Home for individuals living with at mental illness*
        - *Expansion of Targeted Case Management to serve 90 additional individuals*
        - *Created the Community Intervention Specialist , Quality Assurance Coordinator, and Behavioral Health Prevention Coordinator positions*
        - *Pathways to Permanent Housing*
        - *Additional Supported Housing units*
        - *Peer Pipeline Infrastructure*
    - *CEX $4.4 million in 2013 & 2014*
        - *COLA for the CSP agencies*
        - *ACT/IDDT Implementation*
        - *Peer Run Recovery Center*
        - *Southside Access Clinic*
        - *Expansion of 3rd Shift Mobile Crisis*
        - *TCM for the AODA Population*
        - *Relocation funds for Rehab Central Clients*
- Increased the use of evidence based practices with the Individual Placement and Support (IPS) supported employment program.
- In 2014 four Community Support Programs adopted an Assertive Community Treatment/Integrated Dual Disorder Treatment (ACT/IDDT) model.
- Developed a continuum of care in Targeted Case Management (TCM) so individuals in need of TCM service have more choice that is based on clinical acuity; there are now three levels of TCM service. Level I is outreach based case management and care coordination that assists individuals with referrals and information; Level II, is intensive clinic based case management services; and, Level III which is called Recovery Case Management for clients who require less intensive services than what is provided in Level I such as those in need of case management services that reside in a supported apartment.
- 2014 expanded Targeted Case Management to individuals with a substance use disorder, currently 40 clients are enrolled.
- September 2014 received approval for Comprehensive Community Services (CCS) in the County, with 41 clients currently enrolled.

- Improved discharge planning for acute inpatient stays by completing a discharge conference with every individual prior to release to collaboratively review the discharge plan, discuss community resources, and address questions.
- BHD has implemented a multipronged approach toward benefits counseling to ensure maximum revenue to fund services.
    - Social workers work with clients on financial questions and connect individuals with the fiscal department to assist with some components of the benefits application.
    - In addition, Winged Victory Program staff, all of whom are certified application counselors (CAC) for ACA, work with clients in the hospital, PCS, and the Access Clinic to enroll in Medicaid, the Marketplace, and/or social security benefits.
    - Social workers across the network assist clients with the insurance enrollment process.
    - The Community Services Branch has 5 CAC and has worked with our community providers to answer Medicaid and ACA enrollment questions.
    - All Central Intake Units are CAC organizations enrolling nearly 300 individuals into the marketplace or Medicaid from late 2013 to September 2014.

HSRI Rec 6: Promote a recovery-oriented system through person-centered approaches & peer supports

- Milwaukee currently has 111 certified peer specialists- the most in the state.
- Offered training though Our Space, Inc., and La Causa and continuing education opportunities for Certified Peer Specialists.
- In 2014, all contracted TCM and CSP providers employed a Certified Peer Specialist.
- Division of Housing utilized peer specialist in their supported housing programs
- In September 2012 and in September 2013, held a summit for employers on how to recruit/hire/utilize Peer Specialists, second summit occurred in November 2013 and showcased the newly developed Employer Tool Kit
- Sponsored training for local peers as facilitators in developing individualized person-centered Wellness Recovery Action Plan (WRAP).
- Training for bilingual Certified Peer Specialists.
- One community partner, Our Space Inc., employs 25 peer specialists.
- Crisis Services has had significant gains in the number of clients with individualized crisis plans on file with an increase of 206% from 2010 – 2014..
- Peer Pipeline website was created and is maintained by Mental Health America, with up-to-date resources on educational and employment opportunities for peer specialists.
- Aurora Behavioral Health hired their first peer specialist in November 2013.

HSRI Rec 7: Enhance & emphasize housing supports

- The creation of 519 supportive housing units has been developed an increase of 109.3% since 2010.
- The creation of a new supportive services program has been developed for homeless veterans.
- Opened Pathways to Permanent Housing program in June 2013.
- In 2013, the housing division began to use CDGB to fund services in supportive housing including peer support.
- Permanent supportive housing options have been expanded through an increased number of permanent supportive housing units in the community, in addition to 40 scattered site supportive housing options.
- Housing Division has created case management slots for homeless veterans to give individuals access to Shelter Plus Care rental assistance funds. Homeless prevention activities will also be funded from this contract.
- Funds have been committed in 2013 to provide supportive housing for individuals who are aging out of the foster care system and are receiving services through Wraparound. These units will be placed in service in early 2014.

- Finally, as part of establishing a full and active partnership with the homeless service system the Division of Housing has a community intervention specialist who is dedicated to be that bridge between the homeless and mental health systems.
- The housing division created a community intervention specialist position to assist correction institutions, private hospitals and shelters with housing discharge plans.

HSRI Rec 8: Ensure cultural competency

- Cultural Intelligence Action Team (CQAT) established in June 2013 and playing an active role in system redesign efforts.
- Families Moving Forward and the Faith Partnership Network developed and implemented preventative intervention strategies for the African American community in Milwaukee and delivered these interventions in environments needed for effective service.
- United Community Center (UCC) in partnership with the 16th Street Clinic (an FQHC) developed and implemented a collaborative engagement, screening and referral pilot project called *Familias Sanas*. The collaborative project was designed as the pilot for developing systems to increase participation in integrated treatment services (Medical, Mental Health and Substance Use Disorder (SUD) services) for Hispanic population within Milwaukee County.
- A major part of the SMART goals has been enhancing the inclusion of diverse perspectives and increasing the cultural intelligence of mental health and substance use disorder professionals and the public at large.
- In April 2014, 26 individuals participated in the first cultural intelligence (CQI) training and subsequent training is scheduled for November 2014.
- CQI will become a regular training in the Basics of Community Treatment.

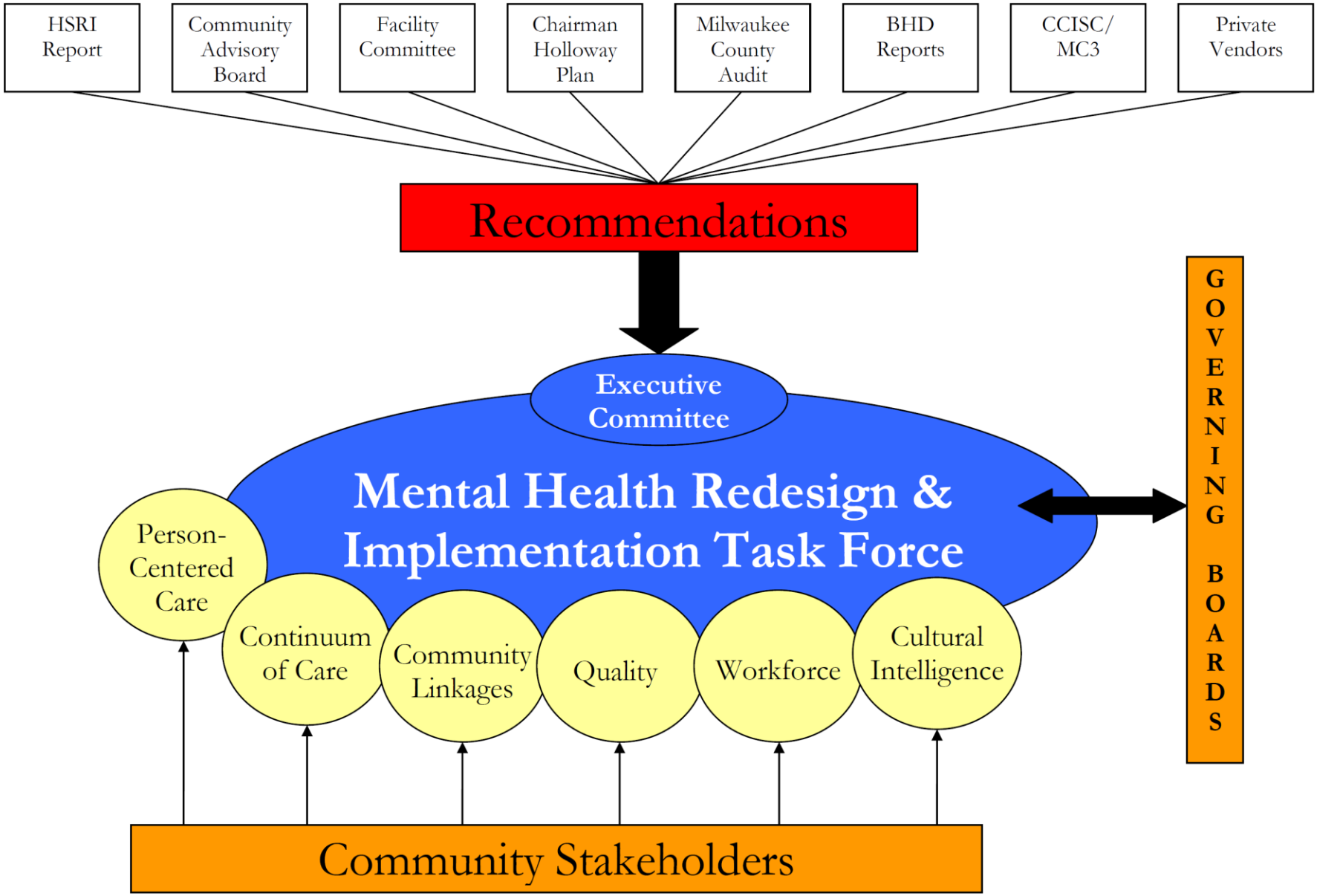
HSRI Rec 9: Ensure trauma-informed care

- A division-wide Trauma Informed Care (TIC) Committee was created.
- Providing BHD staff ongoing TIC based education such as the Mandt System.
- As part of The Joint Commission accreditation preparation process, BHD has updated Division policies and procedures to reflect our trauma informed care approach.
- Incorporated trauma related questions into our universal screening process.
- The Community Services Branch has trained over 500 clinical and recovery support providers on the use of TIC with the curriculum developed by Stephanie Covington.
- Three evidence based trauma treatment models are used in community services – those models are Seeking Safety, Beyond Trauma, and TREM/M-TREM.

HSRI Rec 10: Enhance quality assessment & improvement programs.

- Created an Office of Compliance, Safety & Integrity and have a Chief Compliance Officer overseeing the quality assurance and safety for the Division.
- Revised and improved out QI process to improve the tracking of patient outcomes and effectives of methods being utilized.
- Implementing the EMR system (Avatar) which is a major change to our whole division's management information systems that allows us to collect and report common data.
- With technical assistance from SAMSHA, BHD implemented a self-assessment tool that is being used in 60% of the behavioral health programs.
- Safety and prevention has been a major focus exemplified in the Falls Prevention program which has helped to significantly reduce the number of fall incident among our residents.
- Added a Quality Assurance Coordinator in 2014 dedicated to crisis services.

Attachment 3 – Task Force and Action Team Organizational Chart



Mental Health Redesign SMART[1] Goals: 2013 – 2014

Mental Health **Redesign** Task Force

TIMEFRAME

Redesign is about designing a system that promotes life and hope for people in Milwaukee County with mental health needs by transitioning to a more fully community-based system of care. Redesign is a multi-year process with ambitious targets. Initial SMART Goal implementation is focused on identifying attainable and measurable goals/objectives that can be achieved within the next 12-18 months. There will then be Annual Community Progress Reports of the SMART Goals to chart progress toward the highest possible standards for all services.

[1] Specific, Measurable, Attainable, Realistic, and Time-bound

SCOPE

The Mental Health Redesign addresses the improvement of mental health services for Milwaukee County residents served by public and private systems and organizations. Initial SMART Goals focus heavily on changes in the public sector system operated by the Milwaukee County Department of Health and Human Services while implementation planning continues on broader communitywide improvements involving major hospital systems, provider organizations, advocates, and persons with lived experience. Monthly progress reports on the SMART Goals and Improvement Areas will continue to be made to the County Board and the community.

ORGANIZATION OF SMART GOALS

Goals are organized into five improvement areas consistent with the monthly progress reports that have been provided on the Redesign process:

1) System of Care
2) Crisis System Redesign
3) Continuum of Community-Based Services
4) Integrated Multi-System Partnerships
5) Reduction of Inpatient Utilization

SMART Goal 2013-2014

one

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve satisfaction and recovery outcomes by:

- Using person-centered experiences to inform system improvement.
- Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally intelligent, and co-occurring capable;
- Improving system-wide implementation of such services;
- Increasing the use of self-directed recovery action plans;
- Completing the functional integration of substance use disorder and mental health service components of the Milwaukee County Community Services Branch; and

1

PERFORMANCE TARGETS

By July 2014:

1) Satisfaction as measured by the MHSIP (Mental Health Statistics Improvement Program) Consumer Survey will show measurable improvement for Milwaukee County Behavioral Health Division's Acute Adult Inpatient and Community Services Branch, including residential, supported apartments, community support programs, targeted case management programs, and day treatment with the long range goal of meeting or exceeding the National Research Institute satisfaction standards.
2) Satisfaction as measured by Vital Voices interviews will show measurable improvement for Milwaukee County Crisis Services.
3) 80% of Milwaukee County Behavioral Health Division directly operated services and contracted services will demonstrate adherence to the Mental Health Redesign Core Competencies relative to the principles of person-centered care. (See Goal 3)
4) Integration of substance use disorder and mental health services in the Milwaukee County will be achieved.
5) Consistent mechanism for using person-centered stories in quality improvement is established.

TACTICAL OBJECTIVES

1.1 Review MHSIP and Vital Voices survey instruments to determine if enhancements are required to capture person-centered principles.

1.2 Continue implementation of evidence-based practices to improve the extent to which services are welcoming, person-centered, recovery-oriented, trauma-informed, culturally intelligent, and co-occurring capable; and anchor those improvements in policy and contract.

1.3 Coordinate the activities of MC3 (Milwaukee Co-Occurring Competency Cadre) Evaluation Subcommittee with the efforts of the Redesign Quality Action Team to insure representation of person-centered stories in quality improvement.

1.4 Develop and implement strategies to increase the use of self-directed recovery action plans by establishing a baseline of current use, identifying training opportunities, and measuring adoption by peers.

1.5 Lead the integration of substance use disorder and mental health services into a co-occurring capable system by functionally integrating SAIL and WIser Choice at the Community Services Branch and provider levels.

RESPONSIBILITY

Action Team Involvement:
Person-Centered and Quality

Partners:
Persons with lived experience; Community Services Branch; MC3; providers; Vital Voices; Families United; Mental Health Task Force

BHD Staff Partner:
Jennifer Wittwer

SMART Goal 2013-2014

two

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Promote stigma reduction in Milwaukee County through:

- Evidence-based MH/AODA stigma reduction public education presentations that include presentations by persons with lived experience to over 1000 residents in Milwaukee County supervisor districts.
- Partnering with community efforts already underway led by NAMI, Rogers InHealth, and the Center for Urban Population Health Project Launch.

2

PERFORMANCE TARGETS

By July 2014:

1) Presentations are conducted in 18 Supervisory Districts with an average of 55 residents in attendance at each (total of 1,000 residents).
2) Stigma reduction message is received by a minimum of 20,000 Milwaukee County residents.

TACTICAL OBJECTIVES

2.1 Develop a program to be delivered within each Supervisory District that includes an evidence-based stigma reduction model and a presentation by one or more persons with lived experience.

2.2 Provide support and technical assistance to community efforts to reduce stigma.

RESPONSIBILITY

Action Team Involvement:
Person-Centered

Partners: Milwaukee County Supervisors; Mental Health Task Force; NAMI; Rogers InHealth; Wisconsin's Initiative for Stigma Elimination (WISE); Center for Urban Population Health; Persons with lived experience

BHD /DHHS Staff Partner:
Tonya Simpson

three

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve the quality of the mental health workforce through:

- Implementation of workforce competencies aligned with person-centered care;
- Improved mental health nursing recruitment and retention;
- Improved recruitment and retention of psychiatrists; and
- Improved workforce diversity and cultural competency.

3

PERFORMANCE TARGETS

By July 2014:

1) Establish person-centered workforce competencies.
2) 50% of Milwaukee County contracted behavioral health providers will adopt person-centered workforce competencies.
3) Plan to improve the retention of mental health nurses is completed.
4) One (1) training slot is established for the 2014-2015 involving a partnership of Medical College of Wisconsin Department of Psychiatry and the Milwaukee County Behavioral Health Division.
5) A baseline on the current racial/ethnic composition of the mental health workforce is established.

TACTICAL OBJECTIVES

3.1 Develop person-centered workforce competencies that are recovery-oriented, trauma-informed, co-occurring capable, and culturally-competent.

3.2 Develop and implement a plan to introduce the competencies to public and private entities and achieve their adoption.

3.3. Develop and implement a plan to improve the quality and retention of mental health nurses.

3.4 Establish a sustainable partnership between the Medical College of Wisconsin and Milwaukee County to support the annual commitment of one (1) training slot.

3.5 Work with representatives of underserved and underrepresented populations to improve the recruitment and retention of mental health professionals from those community sectors.

RESPONSIBILITY

Action Team Involvement:
Workforce and Person-Centered

Partners:
Nursing's Voice; Faye McBeath Foundation; University of Wisconsin-Milwaukee; Medical College of Wisconsin; Employers

BHD Staff Partner:
Lora Dooley

four

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by:

- Increasing the number Certified Peer Specialists;
- Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability;
- Increasing the number of programs that employ Certified Peer Specialists;
- Establishing a Peer-operated program; and
- Advocating for quality in the delivery of Certified Peer Specialist services.

4

PERFORMANCE TARGETS

By July 2014:

1) Increase the number of Certified Peer Specialists by 20% (10) over the 2013 baseline of 52 Certified Peer Specialists.
2) Increase the number of programs meeting identified target for employing Certified Peer Specialists from the 2013 baseline of eight (8) programs to fifteen (15) programs.
3) Implement one (1) Peer-operated program.

TACTICAL OBJECTIVES

4.1 Continue implementation of the Certified Peer Specialist Pipeline program supported by the Community Services Branch.

4.2 Establish a web-based clearinghouse to post Certified Peer Specialist opportunities.

4.3 Using the fall 2012 Employer Summit as the model, continue efforts to improve employers' effective utilization of Certified Peer Specialists in their programs.

4.4 Continue to incorporate targets for Certified Peer Specialist employment into policy and contracts.

4.5 Support the provision of Certified Peer Specialist training using state-approved curricula.

4.6 Develop and implement a plan to establish a program operated by Certified Peer Specialists.

RESPONSIBILITY

Action Team Involvement:
Workforce

Partners:
Persons with lived experience; Certified Peer Specialist Training Programs; Wisconsin Peer Specialist Employment Initiative

BHD Staff Partner:
Jennifer Bergersen

SMART Goal 2013-2014

five

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve the coordination and flexibility of public and private funding committed to mental health services.

5

PERFORMANCE TARGETS

By October 2013:

1) Redesign Task Force will complete an analysis (mapping) of public and private resources that support mental health services including analysis of Affordable Care Act implications.

By January 2014:

2) Milwaukee County will approve implementation of CRS (Community Recovery Services) consistent with the Wisconsin Medicaid State Plan Amendment under 1915 (i) to create more flexible application of Medicaid waiver funding within appropriate fiscal constraints.

TACTICAL OBJECTIVES

5.1 Establish Resource Strategy Team comprised of finance experts from foundations, private hospital systems, Milwaukee County, State of Wisconsin, and the Public Policy Forum.

5.2 Publish a report on Mental Health Redesign Financing for dissemination and discussion by key stakeholders.

5.3 Designate the Continuum of Care Action Team or form a new CRS Planning Workgroup to advise Milwaukee County on the design of CRS.

5.4 Conduct a review of program and fiscal data to inform the development of the CRS implementation plan.

5.5 Submit the CRS implementation plan to the Milwaukee County Board for review and approval.

RESPONSIBILITY

Action Team Involvement: Resource Strategy and Continuum of Care

Partners: Wisconsin Department of Health Services

BHD Staff Partner: Jim Kubicek, Alex Kotze and Sue Gadacz

six

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals.

6

PERFORMANCE TARGETS

By October 2013:

1) Publish and widely disseminate the first annual Milwaukee County Mental Health Dashboard and Community Progress Report to chart progress on Redesign SMART Goals.

TACTICAL OBJECTIVES

6.1 Establish public/private system quality indicators aligned with the overall system vision.

6.2 Identify and coordinate existing data sets and data sources.

6.3 Determine how to include consumer experiences in the improvement process.

6.4 Identify how improvement targets in SMART Goals will be measured and reported.

6.5 Create information-sharing agreements.

6.6 Prepare initial format for review and modification.

RESPONSIBILITY

Action Team Involvement: Quality

Partners: Persons with lived experience; Data providers

BHD Staff Partner: Sue Gadacz

seven

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process.

7

PERFORMANCE TARGETS

By January 2014:

1) Define and implement a formal partnership structure and process for continuing system improvement that will review progress, address implementation challenges, and pursue opportunities for further enhancement of the Milwaukee County community mental health system.

TACTICAL OBJECTIVES

7.1 Review current membership, charter, and functioning of the Redesign TF.

7.2 Determine need for and objectives of ongoing system improvement partnership.

7.3 Describe and draft a proposed charter, membership, and accountability of the proposed continuing structure.

7.4 Identify a mechanism for formalizing and implementing the continuing structure and process.

RESPONSIBILITY

Action Team Involvement: NA

Partners: NA

BHD Staff Partner: Sue Gadacz with the Redesign Task Force

SMART Goal 2013-2014

eight

Improvement Area 2 – Crisis System Redesign
Creating and sustaining a community-based continuum of crisis services to reduce involuntary commitments and undue reliance on acute inpatient care.

Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment).

8

PERFORMANCE TARGETS

By July 2014:

1) The number of Emergency Detentions at the Milwaukee County Behavioral Health Division will decrease by 10% (720) from the 2012 baseline of 7,204 Emergency Detentions.
2) The percentage of crisis intervention events which are voluntary will increase from 43.2% (2012 baseline) to 48.9% or greater.
3) The number of individuals seen at the Milwaukee County Psychiatric Crisis Service (PCS) who have person-centered crisis plans will increase by 30% over the 2012 baseline of 136.
4) Maintain high volume of Access Clinic service at 2012 baseline of 6,536 visits.

TACTICAL OBJECTIVES

8.1 Develop a partnership between the Redesign Task Force and the current implementation process for developing an integrated, welcoming crisis continuum of care.

8.2 Support the increased utilization of person-centered crisis plans for the prevention of, and early intervention in, crisis situations through training and technical assistance provided countywide.

8.3 Prioritize expansion of the availability and responsiveness of mobile crisis services as well as other community crisis diversion services including walk-in services, clubhouse, and crisis bed options of all types.

8.4 Facilitate earlier access to assistance for a crisis situation for individuals and families through improved public information on how to access the range of crisis intervention services in the community.

8.5 Improve the capacity of law enforcement (Milwaukee Police Department, Sheriff's Office, and municipal police departments) to effectively intervene in crisis situations through expanded Crisis Intervention Training.

8.6 Identify and improve policies and procedures related to crisis response in contracted services to reduce the likelihood that crisis events lead to emergency detention.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; community crisis services providers; private hospital systems; law enforcement; Community Intervention Training

BHD Staff Partner:
Amy Lorenz

nine

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the flexible availability and continuity of community-based recovery supports.

9

PERFORMANCE TARGETS

By July 2014:

1) Establish a continuum of Targeted Case Management (TCM) services that includes four components: Intensive, Crisis, Level I (regular case management), and Recovery.
2) Increase the number of TCM slots by 6% (90) over the 2012 baseline of 1,472 slots.

By December 2014:

3) Establish two additional psycho-social rehabilitation benefits — Community Recovery Services (CRS) and Comprehensive Community Services (CCS) — to provide flexible recovery support in the community.

TACTICAL OBJECTIVES

9.1 Develop, pilot and implement a mechanism for flexible utilization management that supports individualized matching of service intensity with the continuum of case management and other recovery supports.

9.2 Develop, pilot and implement procedures to move from higher to lower levels of support (and conversely) in response to changing circumstances, e.g. crisis.

9.3 Organize a flexible continuum of community recovery supports to be made available to eligible individuals through CRS and CCS.

9.4 Establish metrics to assess the financial and program impacts of this approach.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; Milwaukee County Community Services Branch; Community providers

BHD Staff Partner:
Sue Gadacz

ten

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the success of community transitions after psychiatric hospital admission.

10

PERFORMANCE TARGETS

By July 2014:

1) The percentage of individuals who are discharged from Milwaukee County Psychiatric Crisis Service (PCS) who return to PCS within 90 days will decrease from the 2012 baseline of 32.2% to 27.0%.
2) The percentage of individuals who are discharged from Milwaukee County Acute Adult Inpatient Services who return to that service within 90 days will decrease from the 2012 baseline of 24.1% to 22.0%.

TACTICAL OBJECTIVES

10.1 Establish a flexible, community-based continuum of care that includes formal services and informal community supports. (Goal 9)

10.2 Maintain and strengthen crisis prevention, intervention, and diversion services in the community. (Goal 8)

10.3 Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.

10.4 Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the county.

10.5 Develop and implement a plan to track 90 day readmission data for all hospital partners.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; public and private hospitals; community providers; crisis prevention and intervention services; peer support providers; housing providers

BHD Staff Partner:
Nancyann Marigomen

eleven

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid.

11

PERFORMANCE TARGETS

By July 2014:

1) There will be a measurable increase in the number of persons who receive assistance in completing SSI/SSDI applications.
2) There will be a measurable increase in the number of persons whose applications for SSI/SSDI are approved.

TACTICAL OBJECTIVES

11.1 Establish a 2012 baseline for the number of persons who received assistance in completing SSI/SSDI applications.

11.2 Establish a 2012 baseline for the number of persons whose SSI/SSDI applications were approved.

11.3 Develop a partnership involving the Social Security Administration, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot and implement a plan to improve access to application assistance.

11.4 Increase access to recovery-oriented Protective Payee services for people needing this service.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience, SSI/SSDI application assistance providers, Protective Payee programs, Social Security Administration, community providers

BHD Staff Partner:
Jena Scherer

SMART Goal 2013-2014

twelve

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Increase the number of individuals with mental illness who are engaged in employment, education, or other vocational-related activities.

12

PERFORMANCE TARGETS

By July 2014:

1) The percentage of SAIL enrollees who are employed will increase from the 2012 baseline of .03% employed and .06% looking for work (at 6 month follow-up) to 1.0% employed and 2.0% looking for work.
2) The percentage of persons enrolled in WIser Choice who are employed full or part time will increase from the 2012 baseline of 26.7% (at 6 month follow-up) to 28.0%.

TACTICAL OBJECTIVES

12.1 Begin implementation of the IPS (Individual Placement and Support) Program by the Community Services Branch and its partners.
12.2 Establish a partnership with community mental health services providers, employment service providers, Milwaukee Area Workforce Investment Board, Division of Vocational Rehabilitation, Department of Workforce Development, and employers to identify and address barriers to employment for persons with mental illness.
12.3 Continue work on CRS implementation to obtain support for evidence-based employment practices.
12.4 Utilize Medicaid-supported benefits to assist persons in job and school readiness and employment and education support.
12.5 Work with the Social Security Administration to develop a strategy to address concerns regarding loss of benefits due to employment.
12.6 Leverage existing partnerships with employers and schools to create expanded options.
12.7 Align employment efforts with the expansion of Certified Peer Specialist network. (Goal 4)
12.8 Involve employers and employment assistance providers (public and private) in stigma reduction activities. (Goal 2)
12.9 Fund a job creation project using Milwaukee County CDBG dollars.

RESPONSIBILITY

Action Team Involvement:
Community Linkages

Partners:
Persons with lived experience, Community Services Branch, Milwaukee Area Workforce Investment Board, Grand Avenue Club, Time Exchange, Flexible Workforce Coalition, Division of Vocational Rehabilitation, Department of Workforce Development, employers, schools and colleges

BHD/DHHS Staff Partner:
Sue Gadacz and Jim Mathy

thirteen

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed.

13

PERFORMANCE TARGETS

By July 2014:

1) Achieve a 10% measurable increase in the number of persons discharged from inpatient services and CBRFs that transition to supportive housing compared to 2012 baseline.
2) Increase the percentage of consumers in Milwaukee County (HUD-supported) Shelter + Care who are retained for six months or more from the 2012 baseline of 88% to 90%.
3) Create 25 new units of permanent supportive housing for persons with mental illness.
4) Achieve a measurable decrease in the number of persons who are identified as homeless in the Homeless Management Information System who were previously tenants in Milwaukee County (HUD-supported) Shelter + Care.

TACTICAL OBJECTIVES

13.1 Organize existing supportive housing resources including Permanent Supportive Housing, Shelter + Care, group homes, step-down housing, and other residential resources into a flexible, recovery-oriented continuum that is responsive to persons' needs and preferences.
13.2 Develop the role of the Community Intervention Specialist in assisting with access to housing and retention in housing for people at risk.
13.3 Develop, pilot and implement an intervention approach to provide additional provider, peer and family support services for those at risk of housing loss.
13.4 Improve the capability of supportive housing to provide person-centered, co-occurring capable services in partnership with MC3.
13.5 Develop new housing options specifically for young adults transitioning from foster care.
13.6 Advocate for increased Section 8 and other housing supports.
13.7 Maintain and develop strong partnerships with nonprofit and private housing developers, WHEDA, banks, county and city housing trust funds, and other key stakeholders focused on the development of new supportive housing.

RESPONSIBILITY

Action Team Involvement:
Community Linkages

Partners:
Milwaukee County Housing Division, Milwaukee Continuum of Care, MC3, WHEDA, banks, housing trust funds, CDBG/HOME, providers, persons with lived experience

BHD/DHHS Staff Partner:
Jim Mathy

SMART Goal 2013-2014

fourteen

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by:

- Establishing a data link between the Milwaukee County criminal justice system and Behavioral Health Division that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness;
- Supporting a continuum of criminal justice diversion services for persons with behavioral health needs; and
- Participating in the Community Justice Council as the primary vehicle for communication and planning.

14

PERFORMANCE TARGETS

By July 2014:

1) There is an operating data link that allows individuals with behavioral health needs who have police contact to be diverted to crisis intervention services and the data link has been used successfully for that purpose.

TACTICAL OBJECTIVES

14.1 Monitor the development of the data link project being implemented by the Milwaukee Community Justice Council and offer assistance when appropriate.

14.2 Participate in effort to explore additional diversion initiatives including a mental health court and other evidence-based practices that promote diversion of persons with mental health needs.

RESPONSIBILITY

Action Team Involvement:
Community Linkages

Partners:
Community Justice Council

BHD Staff Partner:
Jim Kubicek

fifteen

Improvement Area 5 – Reduction of Inpatient Utilization
Supporting a recovery-oriented system that permits the reduction of both acute care utilization and long-term care bed utilization.

Reduce the number of people who experience acute hospital admissions through improved access to, and utilization of, non-hospital crisis intervention and diversion services for people in mental health crisis.

15

PERFORMANCE TARGETS

By July 2014:

1) Reduce admissions to Milwaukee County Behavioral Health Division Acute Adult Inpatient Service by 15% (248) over 2012 baseline of 1,650.
2) Reduce the percentage of persons who are readmitted to the Milwaukee County Behavioral Health Division Acute Adult Inpatient Services within 90 days of discharge from the 2012 baseline of 24.1% to 22.0%.

TACTICAL OBJECTIVES

15.1 Successfully implement tactical objectives in Goals 8, 9, 10, 13, and 14.

15.2 Involve all types of providers in the partnership to reduce admissions including crisis services, day treatment, peer support, clubhouse, case management, and informal community supports.

15.3 Focus on improvement of policies, procedures and practices that facilitate early access to crisis intervention by community providers and law enforcement, continuity of care, diversion from hospitalization into crisis resource centers, and rapid step down from hospitalization into intermediate levels of support. (Goal 8)

15.4 Develop a countywide mechanism for triaging availability and flow between high and lower systems of care.

15.5 Develop a plan for collecting baseline data and tracking hospital diversion and utilization percentages across the county.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience, Behavioral Health Division, private hospital systems, providers, crisis services, faith-based and other community-based resources, law enforcement

BHD Staff Partner:
Amy Lorenz and Nancyann Marigomen

SMART Goal 2013-2014

sixteen

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve the level of cultural intelligence (CQ) operating in all components of the behavioral health system by:

- Developing a CQ knowledge base for the system;
- Incorporating CQ standards into program standards and clinical policies and procedures;
- Instituting workforce development strategies that promote CQ;
- Developing an adequately resources and CQ translator and interpreter network;
- Integrating CQ into each SMART Goal in the MH Redesign; and
- Establishing a CQ system improvement plan based on the components listed above.

16

PERFORMANCE TARGETS

By July 2014:

1) CQ System Improvement Plan will be completed.
2) CQ Assessment Instrument is identified/created and used to assess CQ in 60% of Milwaukee County behavioral health system programs.
3) CQ training program established and implemented for a minimum of 75% of staff.
4) Collaboration with community-based organizations focused on the needs of specific ethnic/racial groups will be improved with a key result being improved access to translator and interpreter services.

TACTICAL OBJECTIVES

16.1 Partner with MC3 to incorporate CQ improvement into MC3 process.

16.2 Partner with Workforce Action to integrate CQ into workforce development strategies.

16.3 Develop a user-friendly CQ Assessment Instrument that reflects best practices and is suitable for the local context.

16.4 Establish a mechanism and schedule for the CQ assessment of Milwaukee County behavioral health providers.

16.5 Establish an inclusive CQ collaboration including advocates and providers representing culturally diverse populations.

RESPONSIBILITY

Action Team Involvement:
CQ Action Team

Partners:
Milwaukee County BHD Community Services Branch, Families Moving Forward, Pastors United, Mental Wellness Ministry, Hmong American Friendship Association, La Causa, Gerald Ignace Indian Health Center, and MC3

BHD Staff Partner:
Sue Gadacz

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
1	Improve consumer satisfaction and recovery outcomes by: ➢ Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable ➢ Increasing the use of self-directed recovery action plans ➢ Completing the functional integration of MH/AODA service components of the Milwaukee County CARS Division ➢ Using person-centered experiences to inform system improvement	➢ MHSIP survey revision, supplemental questions developed for more welcoming and person-centered approach ➢ Improvement in all MHSIP domains from 2011 to 2013 on BHD Acute IP units; four of six domains above 70% ➢ Maintaining MHSIP scores above 75% in community services ➢ ACT/IDDT implementation at CARS Division & eight (8) community agencies ➢ Personal & Family Stories Workgroup	➢ General efforts to improve consumer experiences to achieve optimal MHSIP & Vital Voices scores ➢ Expand collection of consumer satisfaction data in more service settings throughout community ➢ Collecting and curating stories from consumers and families for quality improvement and public education ➢ IDDT implementation, enhance co-occurring capability, unified "front door" for MH and AODA
2	Promote stigma reduction in Milwaukee County through: ➢ Evidence-based stigma reduction presentations that include presentations by persons with lived experience ➢ Partnering with efforts led by NAMI, Rogers Memorial Hospital, and the Center for Urban Population Health Project Launch	➢ Stigma reduction curriculum developed involving consumer stories, information on services and recovery; public education sessions held for County Districts 5 & 10 ➢ Performances of NAMI's "Pieces" throughout Milwaukee County ➢ WISE online video library	➢ Additional public education sessions throughout the County in diverse settings, e.g., schools/universities, churches, parks, community centers
3	Improve the quality of the mental health workforce through: ➢ Implementation of workforce competencies aligned with person-centered care ➢ Improved mental health nursing recruitment and retention ➢ Improved recruitment and retention of psychiatrists ➢ Improved workforce diversity and cultural competency	➢ Nursing's Voice: Applied research on skills and attitudes of MH nurses and employers to develop plans for recruitment, retention; relationship-building with educators and MH nurse employers; continuing education and networking opportunities for RNs; internships for nursing students with interest in MH ➢ Over 500 individuals from 87 community agencies actively engaged in MC3 Steering Committee and Change Agent activities ➢ 28 community agencies completed NIATx change projects, four COMPASS Clinics since 2013; change projects shared on MC3 website	➢ Replication and adaptation of Nursing's Voice activities for other mental health professionals ➢ Implementation of person-centered workforce competencies as defined by SAMHSA, MC3, or other sources ➢ Promoting measurement and monitoring of workforce diversity within community agencies to ensure cultural diversity consistent with the population being served ➢ Collect data on recruitment and retention of psychiatrists, nursing staff

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
4	Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by: ➢ Increasing the number Certified Peer Specialists ➢ Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability; ➢ Increasing the number of programs that employ Certified Peer Specialists ➢ Establishing a peer-operated program ➢ Advocating for quality in the delivery of Certified Peer Specialist services	➢ 119 Certified Peer Specialists in Milwaukee County (August 2014), up from 40 in mid-2012 ➢ Established and maintained Peer Pipeline website (collaboration between County and MHA), providing information on training, continuing education, certification, and employment opportunities for CPS ➢ Training for Spanish-speaking CPS ➢ Two employer trainings on integrating peer support into service array, treatment teams ➢ Peer Specialists employed in TCM and CSP ➢ Aurora Psychiatric Hospital employing CPS	➢ Peer-run drop-in center contract to be issued in mid-2014 ➢ Explore engaging Certified Peer Specialists with additional provider organizations and in diverse settings ➢ Establish baseline and optimal goal (based on demand) for number of CPS employed in the community
5	Improve the coordination and flexibility of public and private funding committed to mental health services	➢ Community Recovery Services and Comprehensive Community Services (Medicaid psychosocial rehab benefits) approved, enrollment underway in CARS Division and community partners ➢ Public Policy Forum, BSG providing fiscal analysis and ACA preparation with BHD and CARS Division	➢ Apply fiscal analysis and ACA preparation assessment in strategic planning and annual budgeting ➢ Explore service expansion (e.g., CRS) opportunities based on analyses by HSRI and others
6	Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals	➢ Public data dashboard presented in January 2014 on County website, updated quarterly ➢ System mapping project in collaboration with IMPACT 2-1-1 highlighting service utilization trends by ZIP code, e.g., Ch. 51 commitments ➢ Personal & Family Stories Workgroup	➢ Research on service utilization with IMPACT 2-1-1 and other data ➢ Integrate Personal/Family Stories with Consumer Satisfaction & utilization assessments ➢ Quarterly updates to dashboard ➢ Outreach to private sector for data sharing and analysis ➢ Data repository for public/private system data, with unique PINs to ensure confidentiality and promote cooperation

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
7	Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process	➢ Mental Health Redesign and Implementation Task Force maintaining partnership among public/private stakeholders since July 2011, making public reports and monthly updates to Milwaukee County Board of Supervisors ➢ MC3 Steering Committee & Change Agents assessing co-occurring capabilities and conducting relevant change projects	➢ Adapt to changing oversight of public mental health services, and establish/affirm collective aims for sustaining quality improvement activities and structures, e.g., Quality Action Team
8	Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment)	➢ Implementation of NIATx system improvement technology to provide ongoing QI process ➢ EDs reduced overall and as a percentage of total PCS admissions from 2011 to 2014 (60.8% to 54.1%) ➢ Increase in person-centered crisis plans on file for BHD consumers (surpassed target) ➢ Expanded hours for mobile crisis services	➢ Assess all community crisis support services for broad perspective of available resources (e.g., mobile crisis calls and visits in community, unique crisis respite consumers, etc.) ➢ Categorize and gather data on different types of crisis events
9	Improve the flexible availability and continuity of community-based recovery supports	➢ Recovery Case Management (40 slots) added in April 2013, piloted by MMHA, to complement three existing levels of TCM ➢ Two additional caseloads (50 slots) of Level I Targeted Case Management contracted, maintained with Bell Therapy since April 2013 ➢ CRS and CCS approved and implemented ➢ Central Intake Units trained as Certified Application Counselors for ACA Marketplace	➢ Continue client enrollment in CCS and CRS benefits ➢ Ongoing assessment of demand for and availability of TCM, CRS, CCS, and CSP benefits
10	Improve the success of community transitions after psychiatric hospital admission	➢ Community Intervention Specialist (Housing Division) facilitating discharge planning and housing placements from public and private inpatient services since August 2013 ➢ Community Linkages and Stabilization Program (CLASP) aiding consumers transitioning from inpatient services to community-based care	➢ Establish definition of a successful or sustainable community transition ➢ Gather current, available data on successful community transitions ➢ Measure effectiveness of transition support services; expand or replicate as appropriate

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
11	Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid	➢ Winged Victory provided SSA application assistance to 314 individuals in 2013, an increase of 45% from 2012 and 76% from 2011; approvals up 36% from 2012 to 2013	➢ Establish SOAR Collaborative ➢ Provide benefit counseling in club houses, day program providers, etc. ➢ Monitor ongoing enrollment of clients into public/private insurance plans to establish baseline and work toward 100% coverage
12	Increase engagement of individuals with mental illness in employment, education, or other vocational-related activities	➢ Implemented Individual Placement and Support (IPS) employment model ➢ Improvement in employment status of SAIL and WIser Choice consumers from intake to six-month follow-up in 2013 ➢ Presentation by SSA representative on benefits and work incentives in mid-2013	➢ Examine employment outcomes based on type of employment, e.g., compare performance of various employment models ➢ Review of WIser Choice GPRA data/outcomes
13	Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed	➢ Increased supportive housing units in 2012, 2013, and 2014 by 28% (90 units), 10% (40 units), and 16% (73 units), respectively ➢ Pathways to Permanent Housing program opened in June 2013 ➢ Clarke Square neighborhood initiative providing housing & supportive services for youth aging out of foster care	➢ Maintain high rates of retention in supportive housing ➢ Increase capacity for Community Intervention Specialist Services to support Housing First model ➢ Involve crisis support resources to increase housing permanency ➢ Expand housing efforts to include consumers aging out of foster care
14	Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by: ➢ Establishing a HIPAA-compliant data link between the County criminal justice system and Behavioral Health Division ➢ Supporting a continuum of criminal justice diversion services for persons with behavioral health needs	➢ Community Justice Council analysis of high utilizers in mental health & law enforcement ➢ Crisis Assessment Response Team (CART) reducing unnecessary conveyances to PCS through contracted partnership with MPD; 143 direct CART contacts (July 2013 through March 2014) with individuals in crisis	➢ Coordinate with Wraparound, foster care, BMCW ➢ Expand CIT to include MCSO, parole/probation ➢ Further coordination and development of criminal justice resources, e.g., IMPACT 2-1-1

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
15	Reduce acute hospital admissions through improved access to non-hospital crisis intervention and diversion services for people in mental health crisis	➢ BHD Adult Inpatient admissions down 48.4% from 2010 to 2014 ➢ Access Clinic served 6,310 individuals (2,214 new clients) in 2013, consistent with 2012 and up 46% from 2011 ➢ Implementation of NIATx process improvement technology to provide ongoing Quality Improvement process	➢ Catalog available crisis intervention supports (e.g., public, private, law enforcement, etc.) ➢ Enhance mechanisms to track and link consumers discharged from acute inpatient care with follow-up supports ➢ Analyze utilization data from mobile crisis calls, community visits, crisis respite use, etc., to complement data on reduced inpatient utilization
16	Improve the level of cultural intelligence (CQ) operating in all components of the behavioral health system by: ➢ Developing a CQ knowledge base ➢ Incorporating CQ standards into program standards, clinical policies & procedures ➢ Instituting workforce development strategies that promote CQ ➢ Developing a translator/interpreter network ➢ Establishing a CQ system improvement plan	➢ Cultural intelligence training curriculum adapted from corporate models into content targeted toward behavioral health and social service fields (with SMB Group) ➢ Conducted training of trainers in 2014 with representatives from Action Teams, CARS Division, and other partners ➢ Hosted expert presentation on personal and organizational CQ enhancement	➢ Develop a cultural intelligence inventory, and conduct pre- and post-testing ➢ Provide ongoing trainings for County and contracted providers on range of cultural intelligence issues ➢ Examine whether there are any changes in the cultural sensitivity item on the MHSIP

Attachment 6 – Cultural Intelligence Action Team

Overview of Cultural Intelligence Efforts in Milwaukee

The Milwaukee County Behavioral Health Division Redesign process was well underway when administrators invited former Contract Administrator Rochelle Landingham and contracted provider Shawn Green to a meeting on Redesign efforts. Both women had worked closely with the implementation of BHD's WIser Choice Program and were very familiar with the program as well as other department programs and service.

The BHD Administrators approached the local Coalition affiliate of the Federal Center of Substance Abuse Treatments do discus gaps for consumers of color in Milwaukee County. Expert advice and planning ensued and an invitation was given to Rochelle Landingham and Shawn Green to come to the Redesign Task Force.

At the meeting, the two were struck by the lack of diversity in the room for a group purposed to redesign a system that serves primarily people of color. Several discussions followed that meeting and the two women were offered the opportunity to meet with the expert consultants hired for the Redesign effort. The now emerging group utilized the consultant's to refine their ideas around addressing the absence of culture specific programming and opportunities for program participants.

The group worked to develop and present, to the Redesign Task Force, a request to expand the effort to include and address **Cultural Intelligence** by way of an additional goal as well as Action Team. The Cultural Intelligence (CQ) Center defines this as: "a person's capability to function effectively in situations characterized by cultural diversity. CQ is a critical capability that enhances employee, manager and organizational effectiveness. It also enhances interpersonal interactions in a wide range of social contexts." (http://www.culturalq.com)

Although Redesign Task Force efforts were well underway, Co-Chairs Sue Gadacz and Pete Carlson explored and ultimately introduced a motion to add a Cultural Intelligence Action Team. The request was vetted by the Task Force at-large and approved. Cultural Intelligence (CQ) became the 16th Goal of the Redesign Action Plan and the CQ Action Team (CQAT) began meeting monthly staring July 10, 2013. The CQAT identified five priorities, which are to:

1. Develop an annual CQAT Action Plan
2. Provide training and curriculum
3. Secure data capping (client type and type of service{s} utilized)
4. Insure peer/participant access and outcomes inclusive of strong partnerships
5. Execute program enhancements

The co-chairs actively recruited members of ethnic, disability and other under-represented groups. The Team continues to meet on the second Tuesday of each month at Westcare WI/Harambee, 335 West Wright Street in Milwaukee at noon.

CQ Forging Ahead

The Cultural Intelligence Action Team (CQAT), a component of the Milwaukee County Behavioral Health Division Redesign, has a vision **to increase and enhance the performance levels of direct care, administrative and other related service staff who work with, in or on behave of service participants in the many diverse communities and constituents in and around Milwaukee County.**

The overall goal of the CQAT is **to conceptualize the framework to expand and ensure that cultural intelligence endures throughout and beyond the Redesign efforts**. **This framework should instruct, equip, and offer care providers the tools to effectively interact with care recipients in culturally**

intelligent and appropriate manners as deemed by the care recipients. The desired result is that care providers understand how best to create and utilize strategies that respect and honor the cultural norms, behaviors, and habits of the persons and communities in which they serve/work.

As the system further engages diverse communities, Cultural Intelligence (CQ) serves as the cornerstone of our collective work with individuals, families and the community at-large. CQ provides the opportunity for partnership with and between representatives of the widest possible array of culturally diverse constituencies in Milwaukee and southeastern Wisconsin, to work collaboratively with people and families in service, leadership, provider partners, front line staff, and others to enhance outcomes.

Employing Cultural Capabilities

The Cultural Intelligence Center has identified four capabilities that are consistently constant in the behavior of individuals who are effective in culturally diverse situations. They are:

- **Drive**
- **Knowledge**
- **Strategy**
- **Action**

Having worked for and on behalf of BHD, the co-chairs have an up-close and realistic understanding of the necessity to redesign and correct system flaws. In a letter to legislators the two proposed that the new **Milwaukee County Mental Health Board**:

- Reflects the ethnic diversity of BHD's current and predicted service population
- Legislation includes narrative and measures to ensure that language and cultural-specific services are readily available to service-seekers, based on the demographics of those actively utilizing County/State sponsored, behavioral health services in Milwaukee County and
- Ensure that members of the proposed Board complete the Cultural Intelligence training

Executing **the Action Plan**, the CQAT recruited 25 people, who have been involved in the Redesign process, for the **inaugural Cultural Intelligence training** held on Tuesday, April 1, 2014. On October 29th we conducted the **Passport to Cultural Intelligence training** with 21 people. Each participant completed a CQ assessment and received their personalize analysis of the findings at the trainings.

We welcome the opportunity to talk with you about partnering as a/your human service/faith partner in this important work. We look forward to working with you and please contact us at:

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